POSTOPERATIVE COMFORT.[1]

BY WILLIAM G. LE BOUTILLIER, M.D.,

OF NEW YORK,

Surgeon to the J. Hood Wright Memorial Hospital.

To secure the comfort of patients after operations can readily be shown to be as desirable as to secure freedom from pain during actual operative procedures. The dread of pain to be endured during the performance of operations has almost disappeared from the community, but there persists an impression that subsequent to operations a considerable degree of real pain must be borne. This impression doubtless causes a good many people to decline operations that are advisable but not imperative, so that such operations are deferred to times that may be less favorable, or are not done at all. The result is that the subjects of some infirmities continue to go about less fit for active life than they might be, or exposed to dangers that could be entirely removed. That unnecessary pain after an operation has a depressing effect on a patient, is a statement that does not need to be supported by extended argument. Such depression may in serious cases be sufficient to be of determining import as regards recovery.

That the ordinary amount of pain and discomfort after operations can be reduced, I have found in my own practice. The main modifications of the previous plan of treatment after operations, which I now endeavor to have carried out, are the subject of this paper. The employment of these changes makes the patients much more comfortable than they were a few years ago.

The points of change chiefly refer to relieving thirst, and pain; procuring more rest; stimulating more freely; feeding more and earlier; and the posture of the patient.

---

[1]Read before the New York Surgical Society, March 14, 1906.

Thirst.—At the conclusion of an operation of any extent, the patient receives at once an enema of hot saline solution, to which, if there is any shock, half an ounce to an ounce of whiskey is added. In the majority of cases the salt solution is given alone, as a matter of routine, to supply fluids. Such an enema is repeated every three hours until there is no thirst or the stomach is able to retain fluids and nourishment; or the pulse is of good rate and quality. The amount given varies from a pint to six ounces at each time, in any case being gradually reduced. These enemata of saline solution are usually discontinued before it is necessary to use an enema for the purpose of moving the bowels.

Beginning five or six hours after anæsthesia is suspended, fluid by the mouth is allowed in moderate, and soon, in almost unlimited, quantities. It is given at such temperature as the patient prefers. It is *allowed,* but patients do not as a rule ask for much. When the stomach contents are thick or very acid, water appears to act as a simple diluent so as to diminish the general discomfort and to reduce the frequency of efforts to vomit. From a suggestion of Dr. McCosh I have learned to permit the use of water freely instead of using the stomach-tube, even in cases where there are extensive peritonitis and considerable vomiting.

Patients suffer very little, sometimes not at all, from thirst, in such cases as previously were constantly begging for relief. It is believed that the elimination of the anæsthetic occurs more quickly and that the secretion of urine is less interfered with.

Stimulation.—In order to increase the general resistance to infection, early free stimulation is employed in addition to the saline and whiskey already mentioned. Subcutaneous injections of strychnine gr. 1/30 to gr. 1/20, repeated every three hours, are usually given for 12 to 24 or even 36 hours, after which the same drug is given by the mouth, until the patient's general condition is satisfactory.

Pain.—When there is a probability that there will be much pain, morphine is given before the effect of the anæsthetic has

passed off. It is repeated in sufficient doses to keep the patient comfortable. This is done even in cases of peritonitis. The results reported in cases of peritonitis when treated by Ochsner's method have shown the value of intestinal rest, and I do not hesitate to use morphine after operations to relieve all pain so far as possible. It does not appear that morphine impairs the blood or lymphatic circulation of the peritoneum or intestines, and if it does not, I can see no contraindication to its use.

Laxatives.—Borrowing again from Ochsner's teaching, little magnesium sulphate is used to secure movements of the bowels. That salines have any specific influence on peritonitis does not appear to be the case. No attempt is made to have every patient's bowels move by a time-table, daily or otherwise. The wide individual variations in the frequency with which this function is performed, need not be worried about or altered because a patient has had an operation. The rectal tube is used in the customary way when necessary for accumulated gas in the cœcum. Inflamed intestines have more time to rest when laxatives are not given for 36 or 48 hours. Then an enema is given; or an enema follows a single dose of calomel (grs. $\frac{\ddot{s}s}{y}$ to $\frac{\bar{i}v}{iv}$), or some mild laxative, as for example the pill of aloes and mastich; or a laxative alone is given.

Posture.—The position of postoperative cases is changed frequently when mechanical conditions permit it. It appears to me to be as desirable to change the position of unconscious and weak surgical cases frequently, as it is to do so in cases of typhoid fever. In such cases, lying a long time on the back should be avoided as much as possible, particularly when they are unconscious, on account of the greater likelihood that in this position mouth secretions or vomitus may be inhaled. It may be questioned whether the improvement in results noted when Fowler's position is used, is not due rather to improved pulmonary and circulatory conditions than to modifications in the amount of toxin absorbed from the peritoneal cavity. I have never used Fowler's position, nor its opposite suggested by Clarke of Johns Hopkins; but I do slightly raise the head and

upper part of the body with a back rest, and frequently change the patient's position onto the side. With a sufficiently firm abdominal bandage, there has been no occasion to fear a reopening of abdominal wounds. Back-aches and tender spots from pressure are very much diminished in frequency and in intensity.

Dressings.—The chief remaining source of postoperative pain comes from the dressings. Roughness and carelessness and lack of manual dexterity on the part of wound-dressers are errors that can be remedied. The patient usually knows what is done at the dressing, and from this is apt to form his own opinion as to the skill employed at the operation which he neither saw nor felt. When applying dressings at the close of an operation it is often wise to think of how they are to be removed, if the latter is to be done painlessly. When gauze is stuffed into a wound, its removal should be effected under an anæsthetic, or delayed until it has been loosened from the tissues with which it is in contact. Drainage-tubes and cigarette-drains (gauze wrapped in gutta-percha tissue) can usually be removed practically painlessly. Ordinarily they do not need to be reintroduced and their former sites can be cleansed thoroughly without any pain, by flushing with saline solution introduced through a small glass tube or a rubber catheter. It is needless to say that the patient should be comfortably disposed in a good light, and that injured limbs should be steadily held by assistants during the entire dressing. The plan for the new dressing should be prepared before any part of the old one is disturbed.

Rest.—In general I endeavor to arrange the after-treatment of operative cases so that the patients shall not be disturbed at frequent intervals for various purposes. They need time to rest and if possible should sleep a good deal. In most cases one can secure three-hour periods without disturbance for anything. The rest and the sleep (the latter secured by drugs when necessary), certainly favor the recovery of the patient.

Food.—Patients whose intestines are not worried by

salines and whose bellies are not distended by gas, are usually pretty ready to eat, and they are allowed food early and in such quantities as they can take. Solid food often seems to agree better than liquids. Of course while there is vomiting, and the stomach digests nothing, no food is given by mouth. The more septic the case the more need for feeding it, to increase the resistance to infection.

Long staying in bed is not resorted to unless the patient is too enfeebled to do otherwise. The practice of getting post-typhoidal septic cases out of bed and feeding them, deserves careful consideration on the part of the surgeon.

It is of the utmost importance to adapt the treatment to each individual case, and abandon so far as possible purely routine treatment.